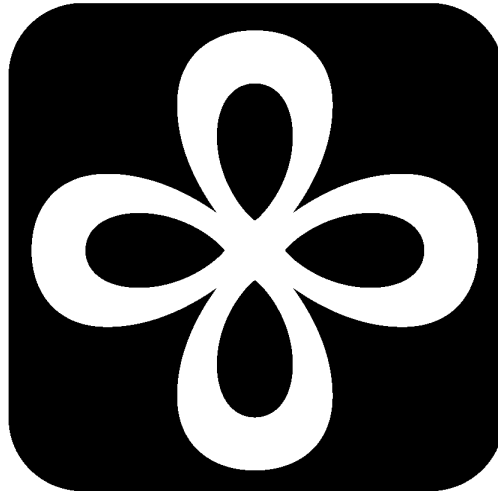


**STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES**

MEDICAID



Provider Manual


Skilled Nursing Facility



CHAPTER E. COVERAGE AND LIMITATIONS

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I. SKILLED NURSING FACILITIES ELIGIBLE TO PARTICIPATE

Nursing homes and hospitals or distinct parts of hospitals currently licensed as nursing facilities by the Iowa Department of Inspections and Appeals are eligible to participate in the Medicaid program. Skilled nursing homes in other states are also eligible if they participate in the Medicare and Medicaid program in that state.

These facilities must meet all of the conditions for participation as skilled nursing facilities in the Medicare program (Title XVIII of the Social Security Act).

Medicare-approved swing-bed hospitals provide skilled facility services. All inpatient skilled facility services shall apply to the swing-bed hospital programs. Client participation and the facility requirements to notify the local DHS office of any change in status of the resident also apply.


A. Certification

Skilled facilities that wish to participate in the Medicare program shall contact the Department of Inspections and Appeals at Lucas State Office Building, Des Moines, Iowa 50319-0075.

The Department of Inspections and Appeals reviews all facilities and notifies the Department of Human Services whether certification is approved or denied.

Facilities are resurveyed to ascertain continued compliance. The Department of Inspections and Appeals will notify the facility of the decision following a resurvey. A finding and certification that the facility is no longer in compliance shall terminate eligibility for participation in the Medicare and Medicaid program through a decertification action.

A facility may appeal a denial of certification or a decertification action according to provisions of the notice.

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B. Agreement for Nursing Facilities and Skilled Nursing Facilities, Form 470-0369

Facilities shall enter into a written agreement with the Department of Human Services, Form 470-0369, Agreement for Nursing Facilities and Skilled Nursing Facilities. A facsimile of the agreement follows on pages 3 and 4.

C. Nondiscrimination Compliance Review for Title VI and Section 504 Regulations, Form 470-0377

Facilities shall complete this form at the time of enrollment in the Medicaid program and periodically thereafter. A facsimile of the agreement follows on pages 5 through 8.

Iowa Department of Human Services

AGREEMENT FOR NURSING FACILITIES AND SKILLED NURSING FACILITIES

This agreement is between:

()

here referred to as “the facility,” and the Iowa Department of Human Services, here referred to as “the Department.”

This agreement covers facility services provided to eligible residents in Medicaid-certified beds and is effective .

As a provider in the Iowa Medicaid Program, the facility agrees and assures that:

1. The facility will maintain admission, discharge, fiscal and other records necessary to document services the facility furnished to recipients for at least five years.
2. The facility will afford the Department and the United States Department of Health and Human Services, through their authorized representatives, the right to review facility records and substantiate claims submitted for payment under the program. The Department will hold information in facility records confidential.
3. The allowable charges determined in accordance with the policy of the Department will be the full and complete payment for the services provided. Except for the amount of client participation, the facility will make no additional charges to residents or family members or any other person for any supplies or services required for the care of the resident.

If any additional payment is received or will be received from any other sources, the facility will deduct that amount from the amount paid by the Department. Any overpayment made by the Department shall be promptly returned to the Department. No Medicaid resident or responsible party shall be charged for items not specifically requested by the resident or responsible party.

4. Payment and satisfaction of claims will be from federal and state funds. Any false claims, statements, and documents or concealment of a material fact may be prosecuted under applicable federal and state laws.
5. The facility will notify the Department 60 days before a planned change of ownership.

6. This agreement may be terminated under the following conditions:
 - a. By the facility by giving 30 days notice to the Department of intent to terminate participation, or
 - b. By the Department by giving 30 days notice to the facility:
 - After it has been determined that the facility is not in substantial compliance with the provisions of this agreement, or
 - When the facility's state license or certification has been terminated or suspended by the regulatory authority, or
 - For any other reason as provided by 441 Iowa Administrative Code 79.2(249A), "Sanctions Against Provider of Care."
7. The facility will not deny service on the basis of race, color, creed, national origin, sex, age, religion, political belief, or physical or mental disability.
8. The facility will comply with the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Age Discrimination Act of 1975, as amended; and the Americans with Disabilities Act of 1990.
9. The facility will provide residents with advance directive material as required by law.
10. The facility will abide by all policy and procedures as explained in the Iowa Administrative Code, the Medicaid Provider Manual for Nursing Facilities or Medicaid Skilled Nursing Facility Manual, and supplemental policy material distributed by the Department.

Authorized Signature of Provider	Authorized Signature of Department
Title	Chief, Bureau of Health Care Purchasing and Quality Management
Date	Date

Instructions:

Please complete and sign both copies and return one copy to: Iowa Department of Human Services, Division of Medical Services, Bureau of Health Care Purchasing and Quality Management, Hoover State Office Building, 5th Floor, Des Moines, Iowa 50319-0114.

We are also enclosing two copies of form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*. Please complete both copies and retain one copy for your files. Return the other copy WITH NO DOCUMENTATION ATTACHED. If you have any questions concerning this matter, call 515-281-4623.

Iowa Department of Human Services

NONDISCRIMINATION COMPLIANCE REVIEW

The Department of Human Services has the responsibility for ensuring that Medicaid providers are in compliance with Title VI of the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973 as amended; and the Age Discrimination Act of 1975, as amended.

Identifying Information			
Facility Name		County	Phone ()
Address			
Legal Auspices:	<input type="checkbox"/> Proprietary	<input type="checkbox"/> Nonprofit	<input type="checkbox"/> Governmental
			Provider No.
Number of Beds			
_____ NF _____ Skilled _____ Other: _____ Total			

Documentation to support the information you provide on this form must be available for inspection at the facility.

Yes No

A. Admission Policies

- ☐ ☐ 1. Does your facility have an admissions policy prohibiting discrimination based on race, color, age, national origin, or disability (mental or physical)?
- ☐ ☐ 2. If such a policy has been adopted, is it in writing and posted?
- ☐ ☐ 3. Have the following been notified in writing of the facility's policy of nondiscrimination: Note: If you answer no to any of the items, explain in Section G.
- ☐ ☐ Community
- ☐ ☐ Employees
- ☐ ☐ Residents
- ☐ ☐ Attending physicians
- ☐ ☐ 4. Is admission to your facility limited to membership in a defined group, e.g. fraternal organization, religious denomination, corporate employee, etc.?
- If so, explain: _____
- _____
5. Specify major referral sources for new admissions: _____
- _____
6. What approximate percentage of your geographic service area population consists of racial minorities?
_____ %

B. Analysis of Residents Admitted During the Previous 12-Month Period

	Total	RACIAL/ETHNIC GROUP IDENTIFICATION					With Disabilities	Age	
		White	Black	Hispanic	Amer. Ind. Alas. Nat.	Asian/ P.I.		Age 40+	39 or less
Men									
Women									
Total									

C. Type of Room Assignment

Number of residents in:	White	Black	Hispanic	Amer. Ind. Alas. Nat.	Asian/ P.I.	With Disabilities
Single room or in room alone						
Semiprivate or ward room with no minority people						
Semiprivate or ward room with only minority people						
Semiprivate or ward room with mixed racial/ethnic groups						
Total						

D. General Availability of Facilities and Services

- Yes No
- ☐ ☐ 1. Are all services and facilities available to and used by all residents without regard to race, color, age, national origin, or disability?
- ☐ ☐ 2. Can any licensed physician or therapist visit or treat a patient who is residing in this facility, regardless of race, color, age, national origin or disability of the patient or practitioner?
- ☐ ☐ 3. Has any qualified person within a disability been denied admission or excluded from participation in any applicable services or programs because the facility is structurally inaccessible? (If so, describe in Section G and state your plan for correction.)
- ☐ ☐ 4. Have persons with disabilities (or organizations representing them) assisted in identifying potential barriers to optimal participation by persons with disabilities in facility programs? (Please describe in Section G.)
- ☐ ☐ 5. Providers with fewer than 15 employees may refer persons with disabilities to an accessible provider only if no means other than a significant alteration in existing facilities available. Do you have a procedure which is followed to ensure that referrals are made under this condition?
- ☐ ☐ 6. Do you have a method of determining where services may be provided at alternate accessible sites in a nondiscriminatory manner?
- ☐ ☐ 7. When assessing a person's eligibility for your programs and services, you use the same procedures for disabled and non disabled?

- ☐ ☐ 8. Are appropriate services provided by your facility to persons with disabilities regardless of the nature of their disability?
- ☐ ☐ 9. Do you admit or treat alcohol or drug abusers in your programs or services on a nondiscriminatory basis?
- ☐ ☐ 10. Is there an effective means of communication for persons with hearing impairments receiving care in your facility?
- ☐ ☐ 11. Are auxiliary aids for persons with disabilities, including those with visual and hearing impairments, used to ensure equal benefit from services?
- ☐ ☐ 12. Has your staff been informed of the auxiliary aids which are available for service to persons who are disabled?
- ☐ ☐ 13. Does your facility have a written policy concerning hiring of bilingual employees to match bilingual characteristics of the population?
- ☐ ☐ 14. Does your facility have a written policy and procedure prohibiting discrimination in employment based on race, color, national origin, religion, sex, age, creed, and disability? If not, describe why in Section G.

E. Current Employment Breakdown

Staff Positions	White		Black		Hispanic		Amer. Ind. Alas. Nat.		Asian/ P.I.		With Disabilities	Age 40+	39 or less
	M	F	M	F	M	F	M	F	M	F			
Administrative													
RN/LPNs													
Nurses Aides													
Dietary													
Housekeeping & Maintenance													
Laundry													
Beauticians & Barbers													
Activities & Social Serv.													
Therapists & Consultants													
Other ()													
Other ()													
Total													

Yes No **F. Grievance**

- ☐ ☐ 1. Does your facility have a written grievance policy and procedure prohibiting discrimination in the delivery of services to residents based on race, color, national origin, age, or disability?
2. Has your facility received a complaint of discrimination based on:
If so, describe in Section G.

Services to Residents:

Yes	Number	No

Treatment of Employees:

Yes	Number	No


- ☐ ☐ 3. Is documentation maintained by your facility which can substantiate the nondiscriminatory practices on the basis of race, color, national origin, age, or disability? At the time of an on-site compliance review or upon request, documentation must be made available.

G. Additional Information (Attach additional sheets, if necessary.)

CERTIFICATION

I CERTIFY THAT THE INFORMATION FURNISHED IN THIS CIVIL RIGHTS REVIEW REPRESENTS ACCURATELY THE POLICIES, PRACTICES, AND CURRENT STATUS OF THIS FACILITY.

Signature of Person Completing Form	Title	Date
Authorized Signature - Administrator	Title	Date

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II. COVERAGE OF INPATIENT SERVICES

Medicaid payment will be made in skilled nursing facilities and swing bed hospitals as medically necessary for those recipients who do not require the level of intensive care ordinarily furnished in a general hospital but for medical reasons need a level of care entailing medically supervised skilled nursing and related services on a continuing basis in an institutional setting.

An incentive factor is added to the payment of most facilities (skilled or swing-bed hospitals) for residents needing ventilator care and meeting criteria for skilled care and ventilator care. The payment section explains the ventilator payment incentive.

Inpatient services allowed in the charges billed to the fiscal agent include but are not limited to: nonprescription drugs, medical equipment, appliances and supplies required by the recipient; occupational, speech, and physical therapy; and prescribed drugs not covered by Medicaid. Charges may be billed for the day of admission but not the day of discharge.


A. Medical Necessity

The determination of medical necessity for skilled care is made by the Iowa Foundation for Medical Care (IFMC), the peer review organization for the state of Iowa. Admission approval is granted when the recipient's functional status meets the "Resident Assessment Services Evaluation" (RASE) criteria. A worksheet listing the required review information is available.

Contact IFMC registered nurse reviewers before the resident's admission to initiate the review process. You may telephone the IFMC at 1-800-383-1173 to initiate a review, to request worksheets, or to obtain additional information. The mailing address of the IFMC is:

Iowa Foundation for Medical Care
6000 Westown Parkway, Suite 350E
West Des Moines, Iowa 50266-7771

The IFMC will notify the fiscal agent of approved stays. The facility notifies the Department through a *Case Activity Report*. See **Section IV**.

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At the time of a resident's condition change or at the time of a regular IFMC review, a facility nurse may bring to the attention of the IFMC reviewer that the facility staff believes the resident may qualify for the skilled level of care. The Department will make retroactive payment for skilled care residents.

1. Lower Level of Care Authorized

Similarly, facilities with residents who no longer need or receive skilled level of care services may have the skilled level of care payment withdrawn based on the IFMC determination. Lower level of care payment is available to the facility if the resident meets the nursing facility level of care and the resident has been determined to be eligible for Medicaid before then.

If your facility is also enrolled as a nursing facility and has its beds certified for both Medicare and Medicaid, you can bill the nursing facility program. Use the nursing facility billing procedure and bill at your facility rate.

If you believe that the denial or discontinuance of the skilled level of care payment was incorrect, you can make a request for a reconsideration in writing to the IFMC. If the IFMC decision is not reversed you have access to the regular Department appeal process.

The level-of-care criteria deal with payment and medical necessity. They do not reflect financial eligibility. The criteria for skilled level of care are described below.

2. Skilled Nursing Services

Direct skilled services are those for which specialized, technical or professional health training is required in order to perform or supervise the services effectively. The need for skilled services is based solely on the services, care, or supervision to be provided, and not on the rehabilitative potential of the resident or the resident's diagnosis.



Skilled nursing service must be furnished by or under the supervision of licensed nursing personnel and under the direction of a physician. A service that could be safely and adequately performed by a person without special training is not a skilled service, even though it may be performed by licensed personnel.

a. Factors frequently indicating a need for skilled care:

- ◆ Skilled nursing services ordered by a physician that are required and provided on a daily basis (seven days a week).
- ◆ Skilled rehabilitative services that are required and provided on a daily basis (at least five days a week or every workday per week).
- ◆ The development, management, and evaluation of a resident's total needs, when the resident's condition is unstable or deteriorating, necessitating involvement of technical or professional personnel (licensed medical personnel) to meet the resident's needs.

When residents exhibit acute psychological symptoms in addition to their physical problems, such as depression or anxiety, or pose a threat to their own safety or the safety of others, the need must be documented by physician orders, nursing, or therapy notes.

This could include development, management, and evaluation of a plan involving an aggregate of unskilled services. Any generally nonskilled service needed because of special complications and special services involved must be documented by physician orders, nursing notes, or therapist's notes.

- ◆ Anticipation of a sudden change in the resident's status. (For example, monitoring of the resident's medications or immediate changes of dosage may be required due to sudden, undesirable effects of the drug or anticipated changes in the resident's condition.)



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- ◆ Technical or professional services needed to teach the patient self-maintenance immediately post-operative (e.g., intensive bowel and bladder retraining, colostomy, or ileostomy training).
- ◆ Transfer from a hospital while the resident is in the complicated, unstablized postoperative period and needs continued close skilled monitoring for postoperative complications or adverse condition.

b. Procedures possibly indicating a need for skilled care:

- ◆ Intravenous infusion, intravenous and intramuscular injections, and nasal-gastric tubes.
- ◆ Levine tube and gastrostomy feedings.
- ◆ Nasal pharyngeal and tracheotomy aspiration on a frequent or a continuous basis.
- ◆ Insertion and sterile irrigation or replacement of a catheter.
- ◆ Application of dressings on a daily basis involving prescription medicine and aseptic techniques.
- ◆ Care of extensive decubitus ulcers or other widespread skin disorders.
- ◆ The initial phase of a regimen involving inhalation therapy. (The initial phase is the first two or three weeks.)
- ◆ Restorative nursing procedures. This includes related teaching and adaptation.
- ◆ Isolation due to contagious or infectious diseases, when medically necessary for the welfare of the resident or other residents.
- ◆ Diabetes (uncontrolled or requiring a period of constant reevaluation and treatment adjustment).
- ◆ Frequent laboratory procedures or diagnostic procedures related to the resident's medication or diagnosis which are otherwise available only on an inpatient basis in an acute hospital.



- ◆ Terminal condition, meaning death is imminent. A physician would be consulted if this is the only factor for placement at the skilled level.
- ◆ Conditions involving multiple complications. A physician would be consulted before placement at the skilled level.
- ◆ Gait training and transfer techniques for restoration of function.
- ◆ Intensive therapy for a patient who cannot be transported except by ambulance. (A physician would be consulted before placement if this is a factor for skilled level care.)
- ◆ Continuous traction.
- ◆ Incontinency, during the training period only the first two to three weeks, when skills and facts necessary for understanding and adherence are taught.

Less serious conditions alone may not justify placement at a skilled level. Multiple factors may necessitate skilled level of care; however, judgment is needed to make this determination.


3. Ventilator Care

The person needing ventilator care must:

- ◆ Require a ventilator at least six hours every day,
- ◆ Have a failed attempt at weaning or are inappropriate for weaning, and
- ◆ Meet other requirements for skilled care.

B. Services Requiring Prior Approval

Out-of-state placements require approval when Medicaid is the primary payer. Reserve bed day payments require approval.

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1. Out-of-State Placements

Medicaid payment will be approved to out-of-state skilled nursing facilities at the rate established by the state in which the facility is located when the following conditions are met:

- ◆ The facility is eligible for participation in Iowa and has agreed to participate in the Iowa Medicaid.
- ◆ The facility has been certified for Medicaid and Medicare participation by the state in which the facility is located.
- ◆ Placement is recommended because moving the resident back to Iowa would otherwise endanger the resident's health, the services provided are not readily available in Iowa or the services out-of-state are cost effective.
- ◆ Care in the out-of-state facility is temporary until services are available to the resident in Iowa or the program of treatment is completed.

Department approval is required before the admission of the resident. Submit requests to the Division of Medical Services, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114.

2. Reserve Bed Days for Visits

Payment for a bed while the resident is absent overnight for a home visit or for participation in a special social or rehabilitation program may be allowed if approval is obtained before the resident leaves the facility.

To obtain payment for the visit days, send a written request to the IFMC. The request for approval must include the following information:

- ◆ The purpose of the visit.
- ◆ Who requested the absence.
- ◆ Assurance that the responsible party can care for the resident.
- ◆ An assurance that the absence is approved in the physician's plan of care.
- ◆ The dates the resident will be absent.
- ◆ The resident's admission date to a facility.



Visit days are available only after a resident has required care in a nursing facility or skilled nursing facility for at least three consecutive months. Visit days are limited to:

- ◆ Ten consecutive calendar days at a time, and
- ◆ A maximum of 18 days in a calendar year.

The facility is responsible for the necessary equipment and supplies needed by the recipient during the absence.

Bill the reserve bed days on the same claim as other inpatient care in the same month. Do not send a separate claim for only reserve bed days in the same month as other inpatient care was provided. Residents cannot begin a stay in a facility on reserve-bed-day status.

3. Reserve Bed Days for Hospitalization

Payment to reserve a bed while a resident is absent overnight for hospitalization is available if approval is obtained before submitting the claim for payment.

Reserve bed days for hospitalization are available if the resident has required care in a nursing facility or skilled nursing facility for at least three consecutive months. Reserve bed days for hospital care do not apply to swing-bed hospitals. Residents cannot begin a stay in a facility on reserve bed day status.

Make the written request for approval to the IFMC as soon as possible, in order to submit the claim for payment. The request must give the dates of hospital care and the beginning date of continuous facility care.

If reserve bed days request are approved, then the IFMC will notify the fiscal agent and the provider. If the request is denied, you will receive a written denial notice.



Payment will not be authorized for:

- ◆ Over ten days in any calendar month.
- ◆ Over ten days for any continuous hospital stay, whether or not the stay extends into a succeeding month or months.

Residents wanting this bed held beyond the allowed Medicaid limits may do so at the Medicaid reserve bed day rate.


Claims for services in a month must also include any reserve bed days for hospitalization. Do not send a separate claim to Medicaid for reserve bed days, unless Medicare is paying all other charges except for the reserve bed days.

C. Relationship to Medicare

Services are paid under the same conditions as in the Medicare program, with the following exceptions:

- ◆ Medicaid does not limit the number of days of skilled care, as long as the services are medically necessary.
- ◆ Medicaid does not require that the person be previously hospitalized.
- ◆ Medicaid recipients who are determined by the IFMC to require only nursing facility level of care are covered with payment made at the average Medicaid nursing facility rate. This rate is effective as of the date of final notice by the IFMC that the lower level of care is required.
- ◆ Reserve-bed-day payments are made for long-term residents.

Even though a Medicaid resident has Medicare and perhaps even a Medicare supplement insurance coverage, you must submit *Case Activity Reports* to the Department on all Medicaid recipients (see **Item IV**), as there are specific policies that affect institutionalized residents.

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D. Exclusions and Limits on Coverage

Skilled nursing care is not a covered service for recipients eligible through the medically needy coverage group.

1. Private Room

There is no provision for extra payment for a private room.

2. Prescribed Drugs

Payment will be approved for covered legend and nonlegend drugs, including insulin. Payment will be made only to the licensed pharmacy of the resident's choice. Payment will not be made to the skilled nursing facility for these drugs.

Exception: This requirement does not apply to hospital-connected facilities and facilities with a retail pharmacy license. Payment will be approved for drugs provided and billed for by those facilities. Pharmaceutical records for Medicaid recipients shall be maintained in accordance with regulations for pharmaceutical services in the Medicare program.

3. Medical and Sickroom Supplies


No payment will be made to a Medicare-certified skilled nursing facility for medical or sickroom supplies furnished for a resident in the facility by a retail pharmacy or a durable medical equipment dealer, **except** for orthotic and prosthetic services and orthopedic shoes.

4. Nonapproved Reserve Bed Days and Discharged Clients

No payment is made to a facility to reserve a bed for a leave that has not been approved by the Department. (See II. B. **Services Requiring Prior Approval**). Also no payment is made after a resident is discharged from the facility.

5. Nonapproved Bed

No payment is made if the person is not in a Medicare- and Medicaid-certified bed.

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III. COVERAGE OF OUTPATIENT SERVICES

Services are paid under the same conditions as the Medicare program. Claims for outpatient services must be billed on the UB-92 claim form.

Outpatient payment will be approved for physical therapy, speech therapy, or occupational therapy provided for outpatients by a therapist on the staff of the facility or under arrangements with the facility.

A claim for outpatient services can be submitted when a patient is receiving nursing facility level of care and does not have Medicare Part B to cover therapy services.

Payment will be approved only when a physician has certified that:

- ◆ Services are or were required because the patient needed therapy services on an outpatient basis.
- ◆ A plan for furnishing the service has been established and is periodically reviewed by the physician. The plan of treatment shall prescribe the type, amount, and duration of the therapy services to be furnished to the patient.
- ◆ Services are or were furnished while the patient is or was under the care of a physician.



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IV. COMMUNICATIONS WITH DEPARTMENT

The Department needs additional information from the facility when a Medicaid-eligible person is in the facility, even if Medicaid is not paying for the cost of care. Provide the information requested on the *Case Activity Report*, form 470-0042, when a resident:


- ◆ Applies for Medicaid.
- ◆ Is admitted to the facility.
- ◆ Is discharged from the facility.
- ◆ Has a change in level of care.
- ◆ Returns to the facility after a leave of more than 10 days.

Send one copy of this form to the county Department of Human Services office as soon as there is a change in the status of a Medicaid recipient or applicant. Keep one copy is retained for your records.

Send one copy to the Iowa Foundation for Medical Care (IFMC) for admissions and discharges and when a resident returns from a hospitalization.

When a resident extends visits or hospitalization beyond approved days, it is important to notify the Department's county office of a resident's return from a hospitalization or visit using form 470-0042.

Note: When a resident of a nursing facility (NF) or residential care facility(RCF) is admitted to a SNF or SNF swing bed facility from a hospital, the SNF shall also **advise the other care facility of the admission**, since this affects the reserve bed eligibility in the other facility. RCFs and NFs are not paid to reserve a bed for a resident receiving SNF care.

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A facsimile of the *Case Activity Report* follows. You may order the form from Iowa State Industries, Anamosa, Iowa 52205, using the form name and the form number. You may obtain a *Form Order Blank* from Iowa State Industries by calling 1-800-332-7922.

Iowa Department of Human Services

CASE ACTIVITY REPORT

Complete this form when a Medicaid applicant or recipient enters or leaves your facility, and when a resident of your facility applies for Medicaid. See the back of this form for instructions.

**Fold line 1. Recipient Data****Fold line**

Name	Social Security Number	State ID	Date Entered Facility
------	------------------------	----------	-----------------------

2. Facility Data

Name	Provider Number	DHS Per Diem
City	Signature of Person Completing Form	Date Completed

3. Level of Care

This information is determined by (IFMC, Medicare or by managed care contractor). Provider number in Item 2 must match the new level of care.

Level of Care	Effective Date
---------------	----------------

4. Medicare Information for Skilled Patients in Skilled Facilities

Do you expect this stay to be covered by Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes, see dates: _____ through _____	Expected dates of full Medicare coverage _____ through _____	Expected dates of partial Medicare coverage _____ through _____
--	---	--

If there is any change in this coverage, please notify the county DHS office.

5. Discharge Data

Date of Discharge	Reason for Discharge
<u>Last Month in Facility</u> (for residents who transfer to another facility or level of care): _____ Days in facility _____ Reserve bed days _____ Non-covered days _____ Total billing days on claim to fiscal agent	<input type="checkbox"/> Died <input type="checkbox"/> Transferred to another facility Name _____ Level of care, if known _____ <input type="checkbox"/> Moved to new living arrangement Address, if available _____

Instructions for Preparing the Case Activity Report:

- ◆ When a current resident applies for Medicaid, complete Sections 1-3. Enter the first name, middle initial, and last name of the resident as they appear on the Medical Assistance Eligibility Card. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1100234G.
- ◆ When a Medicaid applicant or recipient enters the facility or changes level of care, complete sections 1-3, and section 4, if applicable.
- ◆ When a Medicaid applicant or recipient dies or is discharged, complete Sections 1 and 5.
- ◆ This form must be completed within 2 business days of the action.
- ◆ The administrator or designee responsible for the accuracy of this information should sign in Section 2. The date is the date the form is completed and sent to the county Department of Human Services office.

Distribution Instructions for RCFs

Mail the white copy to your county DHS worker. Keep the yellow copy. Discard the pink copy.

Distribution Instructions for NFs, ICF/MRs, SNFs, Mental Health Institutes and Psychiatric Medical Institutions for Children

Mail the white copy to your county DHS worker. Mail the yellow copy to IFMC. Keep the pink copy.

IFMC Address: Iowa Foundation for Medical Care
6000 Westown Parkway Ste 350
West Des Moines IA 50265



V. BASIS OF PAYMENT

The basis of payment for skilled care is prospective. A per diem rate is calculated for each facility by establishing a base year per diem to which an annual index is applied.

The base year per diem rate is the Medicaid cost per diem as determined using the facility's 1998 fiscal year-end Medicare cost report. The base per diem rate for facilities enrolled since 1998 is determined using the facility's first finalized cost report. Determination of allowable costs for the base year is made using Medicare methods in place on December 31, 1998.

A skilled facility's rate is the facility's established costs, not to exceed the ceiling established by the Department. The current ceiling is based on the skilled nursing facilities' 1998 cost report data that has been inflated for current use. The allowable cost is weighted by Medicaid patient days.

For facilities that have elected to receive the low-Medicare-volume prospective payment rate for 1998, the Medicare 1998 prospective payment rate plus ancillary costs attributable to skilled patient-days and not payable by Medicare is used to determine the facility's Medicaid costs per patient day.

Skilled nursing facilities are classified as either hospital-based or free-standing (not hospital-based). A hospital-based facility is a skilled nursing facility under the management and administration of a hospital, regardless of where the skilled beds are physically located.

The maximum payment for a free-standing skilled facility is \$163.41 per day. The maximum payment for a hospital-based facility is \$346.20 per day. Facility rates based on this methodology are effective February 1, 2000.

Notwithstanding the maximum payment rate, free-standing skilled facilities with a case-mix index (derived from MDS reports) that exceeds the Iowa nursing facility case-mix average will receive a semi-annual case-mix adjustment to their daily payment rate of \$5.20, effective July 1, 2000.

A new skilled facility is reimbursed at an interim rate determined by Medicare or, for facilities not participating in Medicare, at an interim rate determined using Medicare methodology. The initial interim rate is either the rate used by Medicare or a per diem developed using Medicare methodology and a projected cost statement from the facility.



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When the facility submits the first cost report to Medicare, the facility shall send a copy to the Medicaid fiscal agent. A new prospective rate will be established based on this cost report, effective the first day of the month in which the cost report is received. Interim and final rates may not exceed maximum allowable costs.

For skilled nursing facilities, a disproportionate share of Medicaid recipients exists when the total cost of services rendered to Medicaid skilled recipients in any one provider fiscal year is greater than or equal to 51% of the facility's total skilled allowable cost for the same fiscal year.

Facilities serving a disproportionate share of skilled residents and enrolled before June 1, 1993, are not subject to any cap on their rates. Facilities that enroll in the Medicaid program on or after June 1, 1993, have an upper limit on their rate not to exceed 150 percent of the maximum rate for the class of skilled nursing facility. The Department determines which providers qualify for this exemption.

Reimbursement for the care of ventilator patients is the maximum allowable cost for the type of facility plus a \$100 per day incentive payment. The revenue code to bill the ventilator care rate is 187. The units of service are the number of days of Medicaid coverage.


Ventilator care is payable as long as the day is covered by Medicaid, even if the client pays for the day with client participation. Payment for ventilator care continues through approved leave days but does not apply to days covered by Medicare or other insurance.

Approved reserve bed payments are made at 75% of the established Medicaid rate for the facility.

Outpatient services are paid based on a percentage of covered charges.

A. Client Participation

Client participation is the amount of money that a resident pays toward the cost of care. Some clients are not assessed client participation. The Department income maintenance worker determines when client participation applies. When a change in the resident's client participation is made retrospectively, the facility must rebill to show the change in client participation if it affects the facility payment.

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1. Medicaid Eligibles

Residents entering skilled nursing care for less than 30 days generally have continuing expenses for maintenance of a home. When the resident enters the facility, the Department's county office determines by contact with the attending physician the approximate length of time the resident is expected to require care.

When a physician expects the stay to last 30 days or less, there is no client participation. When the resident's physician indicates the care in excess of 30 days will be necessary, all monthly income in excess of an amount exempted for personal care shall be applied on the cost of care in the facility after the month of admission.

Client participation is applied to the cost of care, including reserve bed days payments. The resident is allowed to keep any unused client participation in a month. Unused client participation in one month is not applied to the next month's cost of care.

Client participation is assessed at the beginning of a calendar month to long-term care facilities (residential facilities, skilled nursing facilities and nursing facilities) for the cost of facility care in a month. Expenditure of client participation is calculated by multiplying the facility Medicaid rate by the number of days of care.

If the care is for reserve bed days, the reserve bed day rate is used for reserve bed days. If the amount applied to the care is less than the total client participation, the remaining client participation is applied to other long term-care facilities providing care later in the calendar month.

The Department notifies the facility of first-month and ongoing client participation on the *Facility Card*, form MA-2139-0. Keep one copy for your records and return one copy to the recipient's county Department office.

Collection of this amount is between the facility and the resident. The client participation shall not be collected when insurance pays the total cost of the facility care at the Department's established rate. Client participation is applied to the Medicare copayments after day 20 if there is no Medicare coinsurance.



Client participation applies to the facility's per diem rate. It is not applied to the extra payment for ventilator care. A facility may not collect more client participation than what Medicaid would have paid for the care.

The personal needs allowance is \$30 for the resident. Some residents will receive an SSI monthly check from the Social Security Administration for this purpose.

2. Qualifying Medicare Beneficiaries Only

Residents whose only Medicaid coverage is under the qualified Medicare beneficiary group can be identified by their Medicaid card. The card states “**Valid for Medicare deductibles and coinsurance only.” (See Chapter C, sections I. H and V. C for more information.)

These residents do not have any client participation. Medicaid will pay any coinsurance due. It is important to enter the resident's Medicaid number on the Medicare claim for service.

3. Facsimile of Facility Card, Form MA-2139-0

MA-2139-0 470-0371

BEG. ELIG. DATE
END. ELIG. DATE

1ST MO. CLI. PART
ONGO. CLI. PART


ADMINISTRATOR _____

☐

RETAIN FOR
YOUR RECORDS

☐

SEND 1 COPY
TO THE COUNTY

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B. Prohibition Against Charges to Resident or Others

A facility that participates in the Medicaid program must agree to accept payments from the client participation and the Medicaid program as full reimbursement for services provided. The facility shall make no additional charges to the resident or others.

This prohibition also applies to advance payments required as a condition of admittance to the facility, unless these payments are shown as credit on the claim submitted to the fiscal agent. When it is established that a facility has made an additional charge to the resident or to others for covered services, this will be cause for removal from participation in the Medicaid program.



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I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the UB-92 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	PROVIDER'S NAME, ADDRESS & TELEPHONE NUMBER	OPTIONAL – Enter the complete name, address, and phone number of the billing facility or service supplier.
2.	PAYER CONTROL NUMBER	LEAVE BLANK.
3.	PATIENT CONTROL NUMBER	OPTIONAL – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
4.	TYPE OF BILL	REQUIRED* – Enter a three-digit number consisting of one digit from each of the following categories in this sequence: First digit Type of facility Second digit Bill classification Third digit Frequency



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		<u>Type of Facility</u> 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice <u>Bill Classification</u> 1 Inpatient hospital, inpatient SNF or hospice (nonhospital based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient SNF or hospice (hospital based) 4 Hospital referenced laboratory services, home health agency, rehabilitation agency <u>Frequency</u> 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
5.	FEDERAL TAX NUMBER	OPTIONAL – No entry required.
6.	STATEMENT COVERS PERIOD	REQUIRED – Enter the month, day, and year under both the From and To categories for the period.
7.	COVERED DAYS	REQUIRED FOR INPATIENT* – <u>Inpatient, PMIC, and SNF</u> – Enter the number of covered days. Do not use the day of discharge in your calculations. <u>Rehabilitation Agency</u> – Enter the number of days the patient was seen in this billing period. The number of days is used to determine copayment liability. <u>Hospice Services and Home Health Agencies</u> – Leave blank.



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8.	NONCOVERED DAYS	REQUIRED FOR INPATIENT, WHERE APPLICABLE* – <u>Inpatient, PMIC, and SNF</u> – Enter the number of non-covered days, if applicable. Do not use the day of discharge in your calculations. <u>Hospice Services, Rehabilitation, and Home Health Agencies</u> – Leave blank.
9.	COINSURANCE DAYS	OPTIONAL – No entry required.
10.	LIFETIME RESERVE DAYS	OPTIONAL – No entry required.
11.	UNLABELED FIELD	OPTIONAL – No entry required.
12.	PATIENT NAME	REQUIRED – Enter the last name, first name, and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
13.	PATIENT ADDRESS	OPTIONAL* – Enter the full address of the recipient.
14.	PATIENT BIRTHDATE	OPTIONAL – Enter the recipient's birthdate as month, day, and year. Completing this field may expedite processing of your claim.
15.	PATIENT SEX	REQUIRED – Enter the patient's sex.
16.	PATIENT MARITAL STATUS	OPTIONAL – No entry required.
17.	ADMISSION DATE	REQUIRED* – <u>Inpatient, PMIC, and SNF</u> – Enter the date of admission for inpatient services. <u>Outpatient</u> – Enter the dates of service. <u>Home Health Agency and Hospice</u> – Enter the date of admission for care. <u>Rehabilitation Agency</u> – No entry required.



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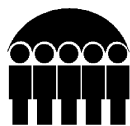
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18.	ADMISSION HOUR	<p>REQUIRED FOR INPATIENT/PMIC/SNF – The following chart consists of possible admission times and a corresponding code. Enter the code that corresponds to the hour patient was admitted for inpatient care.</p> <table border="1"> <thead> <tr> <th>Code</th><th>Time - AM</th><th>Code</th><th>Time - PM</th></tr> </thead> <tbody> <tr> <td>00</td><td>12:00 - 12:59</td><td>12</td><td>12:00 - 12:59</td></tr> <tr> <td></td><td>Midnight</td><td></td><td>Noon</td></tr> <tr> <td>01</td><td>1:00 - 1:59</td><td>13</td><td>1:00 - 1:59</td></tr> <tr> <td>02</td><td>2:00 - 2:59</td><td>14</td><td>2:00 - 2:59</td></tr> <tr> <td>03</td><td>3:00 - 3:59</td><td>15</td><td>3:00 - 3:59</td></tr> <tr> <td>04</td><td>4:00 - 4:59</td><td>16</td><td>4:00 - 4:59</td></tr> <tr> <td>05</td><td>5:00 - 5:59</td><td>17</td><td>5:00 - 5:59</td></tr> <tr> <td>06</td><td>6:00 - 6:59</td><td>18</td><td>6:00 - 6:59</td></tr> <tr> <td>07</td><td>7:00 - 7:59</td><td>19</td><td>7:00 - 7:59</td></tr> <tr> <td>08</td><td>8:00 - 8:59</td><td>20</td><td>8:00 - 8:59</td></tr> <tr> <td>09</td><td>9:00 - 9:59</td><td>21</td><td>9:00 - 9:59</td></tr> <tr> <td>10</td><td>10:00 - 10:59</td><td>22</td><td>10:00 - 10:59</td></tr> <tr> <td>11</td><td>11:00 - 11:59</td><td>23</td><td>11:00 - 11:59</td></tr> <tr> <td></td><td></td><td>99</td><td>Hour unknown</td></tr> </tbody> </table>	Code	Time - AM	Code	Time - PM	00	12:00 - 12:59	12	12:00 - 12:59		Midnight		Noon	01	1:00 - 1:59	13	1:00 - 1:59	02	2:00 - 2:59	14	2:00 - 2:59	03	3:00 - 3:59	15	3:00 - 3:59	04	4:00 - 4:59	16	4:00 - 4:59	05	5:00 - 5:59	17	5:00 - 5:59	06	6:00 - 6:59	18	6:00 - 6:59	07	7:00 - 7:59	19	7:00 - 7:59	08	8:00 - 8:59	20	8:00 - 8:59	09	9:00 - 9:59	21	9:00 - 9:59	10	10:00 - 10:59	22	10:00 - 10:59	11	11:00 - 11:59	23	11:00 - 11:59			99	Hour unknown
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19.	TYPE OF ADMISSION	<p>REQUIRED FOR INPATIENT/PMIC/SNF – Enter the code corresponding to the priority level of this inpatient admission.</p> <p>1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable</p>																																																												
20.	SOURCE OF ADMISSION	<p>REQUIRED FOR INPATIENT/PMIC/SNF – Enter the code that corresponds to the source of this admission.</p> <p>1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information unavailable</p>																																																												



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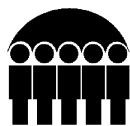
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21.	DISCHARGE HOUR	<p>REQUIRED FOR INPATIENT/PMIC/SNF – The following chart consists of possible discharge times and a corresponding code. Enter the code that corresponds to the hour patient was discharged from inpatient care.</p> <p>See Field 18, Admission Hour, for instructions for accepted discharge hour codes.</p>
22.	PATIENT STATUS	<p>REQUIRED FOR INPATIENT/PMIC/SNF – Enter the code that corresponds to the status of the patient at the end of service.</p> <ul style="list-style-type: none">01 Discharged to home or self care (routine discharge)02 Discharged/transferred to other short-term general hospital for inpatient care03 Discharged or transferred to a skilled nursing facility (SNF)04 Discharged or transferred to an intermediate care facility (ICF)05 Discharged or transferred to another type of institution for inpatient care or outpatient services06 Discharged or transferred to home with care of organized home health services07 Left care against medical advice or otherwise discontinued own care08 Discharged or transferred to home with care of home IV provider10 Discharged or transferred to mental health care11 Discharged or transferred to Medicaid-certified rehabilitation unit12 Discharged or transferred to Medicaid-certified substance abuse unit13 Discharged or transferred to Medicaid-certified psychiatric unit20 Expired30 Remains a patient or is expected to return for outpatient services (valid only for non-DRG claims)



23.	MEDICAL/ HEALTH RECORD NUMBER	OPTIONAL – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
24. – 30.	CONDITION CODES	<p>CONDITIONAL* – Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below.</p> <p>Up to seven codes may be used to describe the conditions surrounding a patient's treatment.</p> <p><u>General</u></p> <p>01 Military service related 02 Condition is employment related 03 Patient covered by an insurance not reflected here 04 HMO enrollee 05 Lien has been filed</p> <p><u>Inpatient Only</u></p> <p>80 Neonatal level II or III unit 81 Physical rehabilitation unit 82 Substance abuse unit 83 Psychiatric unit X3 IFMC approved lower level of care, ICF X4 IFMC approved lower level of care, SNF 91 Respite care XG No prior qualifying Medicare stay</p> <p><u>Outpatient Only</u></p> <p>84 Cardiac rehabilitation program 85 Eating disorder program 86 Mental health program 87 Substance abuse program 88 Pain management program 89 Diabetic education program 90 Pulmonary rehabilitation program 98 Pregnancy indicator – outpatient or rehabilitation agency</p>



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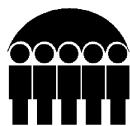
		<u>Special Program Indicator</u> A1 EPSDT A2 Physically handicapped children's program A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery <u>Home Health Agency</u> (Medicare not applicable) XA Condition stable XB Not homebound XC Maintenance care XD No skilled service
31.	UNLABELED FIELD	OPTIONAL – No entry required.
32. – 35. A. & B.	OCCURRENCE CODES AND DATES	REQUIRED IF APPLICABLE* – If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence. <u>Accident Related</u> 01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim



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		<u>Insurance Related</u> 17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted <u>Other</u> 11 Date of onset
36. A. & B.	OCCURRENCE SPAN CODES AND DATES	OPTIONAL – No entry required.
37. A. – C.	TRANSACTION CONTROL NUMBER	LEAVE BLANK.
38.	RESPONSIBLE PARTY NAME AND ADDRESS	OPTIONAL – No entry required.
39. – 41. a. – d.	VALID CODES AND AMOUNTS	OPTIONAL – No entry required.
42.	REVENUE CODE	REQUIRED – Enter the appropriate corresponding revenue code for each item or service billed. Replace the “X” with a subcategory code, where appropriate, to clarify the code. Please note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call Provider Relations at 1-800-338-7909 or 515-327-5120 (in Des Moines).



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- | | | | |
|--|--|--|--|
| | | | <p>11X Room & Board – Private (medical or general)
Routine service charges for single bed rooms.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classifications1 Medical/surgical/GYN2 OB3 Pediatric4 Psychiatric6 Detoxification7 Oncology8 Rehabilitation9 Other |
| | | | <p>12X Room & Board – Semi-Private Two Bed (medical or general)
Routine service charges incurred for accommodations with two beds.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classifications4 Sterile environment7 Self care9 Other |
| | | | <p>13X Room & Board – Semi-Private Three and Four Beds (medical or general)
Routine service charges incurred for accommodations with three and four beds.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classifications4 Sterile environment7 Self care9 Other |



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14X Private (deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

15X Room & Board – Ward (medical or general)

Routine service charge for accommodations with five or more beds.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

16X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategories

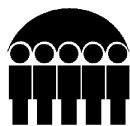
- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

17X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Subcategories

- 0 General classification
- 1 Newborn
- 2 Premature
- 5 Neonatal ICU
- 9 Other



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18X Other Facility Charges

Charges for services not otherwise categorized.

“Reserve bed days” are charges for holding a room or bed for a patient in a nursing facility providing skilled care or a psychiatric medical institution for children while the patient is temporarily away from the facility.

Ventilator charges are for ventilator-dependent clients being served in an inpatient nursing facility providing skilled care.

Refer to Chapter E for a complete explanation.

Subcategory

- 5 Reserve bed days for hospitalization
- 7 Ventilator skilled care
- 9 Reserve bed days for visits

20X Intensive Care

Routine service for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategories

- 0 General classification
- 1 Surgical
- 2 Medical
- 3 Pediatric
- 4 Psychiatric
- 6 Post ICU
- 7 Burn care
- 8 Trauma
- 9 Other intensive care



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21X Coronary Care

Routine service charge for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit.

Subcategories

- 0 General classification
- 1 Myocardial infarction
- 2 Pulmonary care
- 3 Heart transplant
- 4 Post CCU
- 9 Other coronary care

22X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

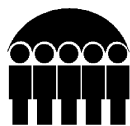
Subcategories

- 0 General classification
- 1 Admission charge
- 2 Technical support charge
- 3 U.R. service charge
- 4 Late discharge, medically necessary
- 9 Other special charges

23X Incremental Nursing Charge Rate

Subcategories

- 0 General classification
- 1 Nursery
- 2 OB
- 3 ICU
- 4 CCU
- 9 Other



24X All Inclusive Ancillary

A flat rate charge incurred on either a daily or total stay basis for ancillary services only.

Subcategories

- 0 General classification
- 9 Other inclusive ancillary

25X Pharmacy

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies.

Subcategories

- 0 General classification
- 1 Generic drugs
- 2 Nongeneric drugs
- 3 Take home drugs
- 4 Drugs incident to other diagnostic services
- 5 Drugs incident to radiology
- 6 Experimental drugs
- 7 Nonprescription
- 8 IV solutions
- 9 Other pharmacy

26X IV Therapy

Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategories

- 0 General classification
- 1 Infusion pump
- 2 IV therapy/pharmacy services
- 3 IV therapy/drug/supply delivery
- 4 IV therapy/supplies
- 9 Other IV therapy



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- | | | |
|--|--|---|
| | | <p>27X Medical/Surgical Supplies and Devices
(also see 62X, an extension of 27X)
Charges for supply items required for patient care.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Nonsterile supply2 Sterile supply3 Take home supplies4 Prosthetic/orthotic devices5 Pacemaker6 Intraocular lens7 Oxygen – take home8 Other implants9 Other supplies/devices <p>28X Oncology
Charges for the treatment of tumors and related diseases.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification9 Other oncology <p>29X Durable Medical Equipment
(other than renal)
Charges for medical equipment that can withstand repeated use (excluding renal equipment).</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Rental2 Purchase of new DME3 Purchase of used DME4 Supplies/drugs for DME effectiveness
(home health agency only)9 Other equipment |
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30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-92 form field number 44.

Subcategories

- 0 General classification
- 1 Chemistry
- 2 Immunology
- 3 Renal patient (home)
- 4 Nonroutine dialysis
- 5 Hematology
- 6 Bacteriology and microbiology
- 9 Other laboratory

31X Laboratory – Pathological

Charges for diagnostic and routine laboratory tests on tissues and cultures.

For outpatient services, indicate the CPT code for each lab charge in UB-92 form field number 44.

Subcategories

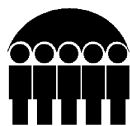
- 0 General classification
- 1 Cytology
- 2 Histology
- 4 Biopsy
- 9 Other

32X Radiology – Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting of radiographs and fluorographs.

Subcategories

- 0 General classification
- 1 Angiocardiology
- 2 Arthrography
- 3 Arteriography
- 4 Chest x-ray
- 9 Other



33X Radiology – Therapeutic

Charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategories

- 0 General classification
- 1 Chemotherapy – injected
- 2 Chemotherapy – oral
- 3 Radiation therapy
- 5 Chemotherapy – IV
- 9 Other

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Subcategories

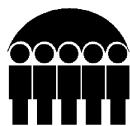
- 0 General classification
- 1 Diagnostic
- 2 Therapeutic
- 9 Other

35X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Subcategories

- 0 General classification
- 1 Head scan
- 2 Body scan
- 9 Other CT scans



36X Operating Room Services

Charges for services provided to patients by those specifically trained nursing personnel providing assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Subcategories

- 0 General classification
- 1 Minor surgery
- 2 Organ transplant – other than kidney
- 7 Kidney transplant
- 9 Other operating room services

37X Anesthesia

Charges for anesthesia services in the hospital.

Subcategories

- 0 General classification
- 1 Anesthesia incident to radiology
- 2 Anesthesia incident to other diagnostic services
- 4 Acupuncture
- 9 Other anesthesia

38X Blood

Charges for blood must be separately identified for private payer purposes.

Subcategories

- 0 General classification
- 1 Packed red cells
- 2 Whole blood
- 3 Plasma
- 4 Platelets
- 5 Leukocytes
- 6 Other components
- 7 Other derivatives (cryoprecipitates)
- 9 Other blood



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39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategories

- 0 General classification
- 1 Blood administration
- 9 Other blood storage and processing

40X Other Imaging Services

Subcategories

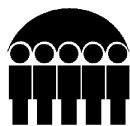
- 0 General classification
- 1 Diagnostic mammography
- 2 Ultrasound
- 3 Screening mammography
- 4 Positron emission tomography
- 9 Other imaging services

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure. Charges for other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Subcategories

- 0 General classification
- 1 Inhalation services
- 3 Hyperbaric oxygen therapy
- 9 Other respiratory services



42X Physical Therapy

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other occupational therapy/trial occupational therapy – rehab agency

43X Occupational Therapy

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other occupational therapy/trial occupational therapy – rehab agency

44X Speech – Language Pathology

Charges for services provided to those with impaired functional communication skills.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other speech-language pathology/trial speech therapy – rehab agency



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45X Emergency Room

Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care.

Subcategories

- 0 General classification
- 9 Other emergency room

46X Pulmonary Function

Charges for tests measuring inhaled and exhaled gases. Charges for the analysis of blood and for tests evaluating the patient's ability to exchange oxygen and other gases.

Subcategories

- 0 General classification
- 9 Other pulmonary function

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Subcategories

- 0 General classification
- 1 Diagnosis
- 2 Treatment
- 9 Other audiology

48X Cardiology

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests.

Subcategories

- 0 General classification
- 1 Cardiac cath lab
- 2 Stress test
- 9 Other cardiology



49X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by other categories.

Subcategories

- 0 General classification
- 9 Other ambulatory surgical care

50X Outpatient Services

Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service.

Subcategories

- 0 General classification
- 9 Other outpatient services

51X Clinic

Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Subcategories

- 0 General classification
- 1 Chronic pain center
- 2 Dental clinic
- 3 Psychiatric clinic
- 4 OB-GYN clinic
- 5 Pediatric clinic
- 9 Other clinic

52X Free-Standing Clinic

Subcategories

- 0 General classification
- 1 Rural health – clinic
- 2 Rural health – home
- 3 Family practice
- 9 Other free-standing clinic



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53X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Subcategories

- 0 General classification
- 1 Osteopathic therapy
- 9 Other osteopathic services

54X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention.

Note: Ambulance is payable on the UB-92 form **only** in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis/documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility.

Subcategories

- 0 General classification
- 1 Supplies
- 2 Medical transport
- 3 Heart mobile
- 4 Oxygen
- 5 Air ambulance
- 6 Neonatal ambulance services
- 7 Pharmacy
- 8 Telephone transmission EKG
- 9 Other ambulance



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| | | | <p>55X Skilled Nursing (home health agency only)
Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Visit charge2 Hourly charge9 Other skilled nursing <p>56X Medical Social Services (home health agency only)
Charges for services such as counseling patients, interviewing and interpreting problems of social situations provided to patients on any basis.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Visit charge2 Hourly charge9 Other medical social services <p>57X Home Health Aide (home health agency only)
Charges made by a home health agency for personnel primarily responsible for the personal care of the patient.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Visit charge2 Hourly charge9 Other home health aide services <p>61X MRI
Charges for Magnetic Resonance Imaging of the brain and other body parts.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Brain (including brainstem)2 Spinal cord (including spine)9 Other MRI |
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| | | <p>62X Medical/Surgical Supplies (extension of 27X)
Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">1 Supplies incident to radiology2 Supplies incident to other diagnostic services <p>63X Drugs Requiring Specific Identification
Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in UB-92 form field number 44.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Single source drug2 Multiple source drug3 Restrictive prescription4 Erythropoietin (EPO), less than 10,000 units5 Erythropoietin (EPO), 10,000 or more units6 Drugs requiring detailed coding <p>64X Home IV Therapy Services
Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Nonroutine nursing, central line2 IV site care, central line3 IV site/change, peripheral line4 Nonroutine nursing, peripheral line5 Training patient/caregiver, central line6 Training, disabled patient, central line7 Training, patient/caregiver, peripheral line8 Training, disabled patient, peripheral line9 Other IV therapy services |
|--|--|---|



65X Hospice Services (hospice only)

Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition.

Subcategories

- 1 Routine home care
- 2 Continuous home care (hourly)
- 5 Inpatient respite care
- 6 General inpatient care
- 8 Care in an ICF or SNF

70X Cast Room

Charges for services related to the application, maintenance, and removal of casts.

Subcategories

- 0 General classification
- 9 Other cast room

71X Recovery Room

Subcategories

- 0 General classification
- 9 Other recovery room

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite.

Subcategories

- 0 General classification
- 1 Labor
- 2 Delivery
- 3 Circumcision
- 4 Birthing center
- 9 Other labor room/delivery



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73X EKG/ECG (electro-cardiogram)

Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments.

Subcategories

- 0 General classification
- 1 Holter monitor
- 2 Telemetry
- 9 Other EKG/ECG

74X EEG (electro-encephalogram)

Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders.

Subcategories

- 0 General classification
- 9 Other EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategories

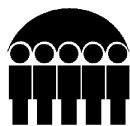
- 0 General classification
- 9 Other gastro-intestinal

76X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes (one unit per hour) on outpatient claims.

Subcategories

- 0 General classification
- 1 Treatment room
- 2 Observation room
- 9 Other treatment/observation room



79X Lithotripsy

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategories

- 0 General classification
- 9 Other lithotripsy

80X Inpatient Renal Dialysis

A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Subcategories

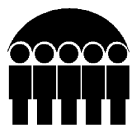
- 0 General classification
- 1 Inpatient hemodialysis
- 2 Inpatient peritoneal (nonCAPD)
- 3 Inpatient continuous ambulatory peritoneal dialysis
- 4 Inpatient continuous cycling peritoneal dialysis (CCPD)
- 9 Other inpatient dialysis

81X Organ Acquisition (see 89X)

The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.)

Subcategories

- 0 General classification
- 1 Living donor – kidney
- 2 Cadaver donor – kidney
- 3 Unknown donor – kidney
- 4 Other kidney acquisition
- 5 Cadaver donor – heart
- 6 Other heart acquisition
- 7 Donor – liver
- 9 Other organ acquisition



82X Hemodialysis – Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategories

- 0 General classification
- 1 Hemodialysis/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient hemodialysis

83X Peritoneal Dialysis – Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategories

- 0 General classification
- 1 Peritoneal/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient peritoneal dialysis

84X Continuous Ambulatory Peritoneal Dialysis (CCPD) – Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer.

Subcategories

- 0 General classification
- 1 CAPD/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient CAPD



85X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night.

Subcategories

- 0 General classification
- 1 CCPD/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient CCPD

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Subcategories

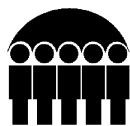
- 0 General classification
- 1 Ultrafiltration
- 2 Home dialysis aid visit
- 9 Miscellaneous dialysis other

89X Other Donor Bank (extension of 81X)

Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see **81X**).

Subcategories

- 0 General classification
- 1 Bone
- 2 Organ (other than kidney)
- 3 Skin
- 9 Other donor bank



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92X Other Diagnostic Services

Subcategories

- 0 General classification
- 1 Peripheral vascular lab
- 2 Electromyelogram
- 3 Pap smear
- 4 Allergy test
- 5 Pregnancy test
- 9 Other diagnostic services

94X Other Therapeutic Services

Charges for other therapeutic services not otherwise categorized.

Subcategories

- 0 General classification
- 1 Recreational therapy
- 2 Education/training
- 3 Cardiac rehabilitation
- 4 Drug rehabilitation
- 5 Alcohol rehabilitation
- 6 Complex medical equipment – routine
- 7 Complex medical equipment – ancillary
- 9 Other therapeutic services

99X Patient Convenience Items

Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered.

Subcategories

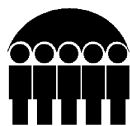
- 0 General classification
- 1 Cafeteria/guest tray
- 2 Private linen service
- 3 Telephone/telegraph
- 4 TV/radio
- 5 Nonpatient room rentals
- 6 Late discharge charge
- 7 Admission kits
- 8 Beauty shop/barber
- 9 Other patient convenience items



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43.	REVENUE DESCRIPTION	OPTIONAL – Enter a description of each revenue code billed.
44.	HCPCS/CPT/RATES	CONDITIONAL* – <u>Outpatient Hospital</u> – Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG. <u>Home Health Agencies</u> – Enter the applicable HCPCS code from the prior authorization when billing for EPSDT-related services. <u>All Others</u> – Leave blank.
45.	SERVICE DATE	OPTIONAL – Entry in this field is optional for outpatient services. No entry required for all others.
46.	UNITS OF SERVICE	REQUIRED – <u>Inpatient</u> – Enter the number of units of service for accommodation days. <u>Outpatient</u> – Enter the number of units of service provided per CPT or revenue code. (Batch-bill APGs require one unit for every 15 minutes of service time.) <u>Home Health Agencies</u> – Enter the number of units for each service billed. A unit of service equals a visit. For prior authorization private duty nursing or personal care, one unit equals an hour.
47.	TOTAL CHARGES	REQUIRED – Enter the total charges for each code billed.
48.	NONCOVERED CHARGES	REQUIRED – Enter the noncovered charges for each applicable code.
49.	UNLABELED FIELD	OPTIONAL – No entry is required.



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50. A. – C.	PAYER IDENTIFICATION	REQUIRED – Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.
51.	PROVIDER NUMBER	REQUIRED – Enter your seven-digit Medicaid provider number.
52. A. – C.	RELEASE OF INFORMATION CERTIFICATION INDICATOR	OPTIONAL – No entry required.
53. A. – C.	ASSIGNMENT OF BENEFITS...	OPTIONAL – No entry required.
54. A. – C.	PRIOR PAYMENTS	REQUIRED – If applicable, enter the amount paid by third-party payer. Do not enter previous Medicaid payments.
55. A. – C.	ESTIMATED AMOUNT DUE	OPTIONAL – No entry required.
56. – 57.	UNLABELED FIELDS	OPTIONAL – No entry required.
58. A. – C.	INSURED'S NAME	REQUIRED – Enter the Medicaid recipient's last name, first name, and middle initial. Verify this information on the <i>Medical Assistance Eligibility Card</i> .
59. A. – C.	PATIENT'S RELATIONSHIP TO INSURED	OPTIONAL – No entry required.
60. A. – C.	CERTIFICATE/ SOCIAL SECURITY NUMBER/HEALTH INSURANCE CLAIM/IDENTI- FICATION	REQUIRED* – Enter the patient's Medicaid identification number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A.



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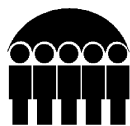
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61. A. – C.	INSURED GROUP NAME	OPTIONAL* – No entry required.
62.	INSURANCE GROUP NUMBER	OPTIONAL* – No entry required.
63.	TREATMENT AUTHORIZATION CODE	CONDITIONAL – If the patient is a MediPASS patient and the service is not an emergency, the physician authorization number must be shown here.
64. – 66.	EMPLOYMENT STATUS, EMPLOYER NAME AND LOCATION	OPTIONAL* – No entry required.
67.	PRINCIPAL DIAGNOSIS CODE	REQUIRED – Enter the ICD-9-CM code for the principal diagnosis.
68. – 75.	OTHER DIAGNOSIS CODES	CONDITIONAL – Enter the ICD-9-CM codes for diagnosis, other than principal, for the additional diagnosis.
76.	ADMITTING DIAGNOSIS	OPTIONAL – No entry required.
77.	“E” CODE	OPTIONAL – No entry required.
78.	DRG ASSIGNMENT	OPTIONAL – No entry required.
79.	PROCEDURE CODING METHOD USED	OPTIONAL – No entry required.
80.	PRINCIPAL PROCEDURE AND DATE	CONDITIONAL – For the principal surgical procedure, enter the ICD-9-CM procedure code and surgery date, when applicable.
81.	OTHER PROCEDURE CODES AND DATES	CONDITIONAL – For additional surgical procedures, enter the ICD-9-CM procedure codes and dates.



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82.	ATTENDING PHYSICIAN ID	<p>REQUIRED –</p> <p><u>Inpatient Hospital, SNF, Rehab Agency, Home Health Agency, and PMIC</u> – Enter the UPIN or seven-digit Iowa Medicaid provider number for the treating physician. The last name, first initial, and discipline are also needed. The treating physician has primary responsibility for the patient's care from the start of hospitalization.</p> <p><u>Outpatient</u> – Enter the UPIN or seven-digit Iowa Medicaid provider number of the physician referring the patient to the hospital. This area should not be completed if the primary physician did not give the referral. On outpatient billings, do not show treating physician information in this area.</p> <p>Note: For lock-in patients, enter the seven-digit Iowa Medicaid provider number of the lock-in physician or clinic in place of the above.</p>
83.	OTHER PHYSICIAN ID	<p>OPTIONAL – Enter the UPIN number of physician performing the principal procedure, if applicable. If a UPIN number is unavailable, enter the physician's seven-digit Iowa Medicaid provider number. The last name, first initial, and discipline are also needed.</p>
84.	REMARKS	<p>OPTIONAL – No entry required.</p>
85.	PROVIDER REPRESENTATIVE SIGNATURE	<p>REQUIRED – The signature of an authorized representative must be shown.</p> <p>If the signature consists of computer-generated block letters, the signature must be initialed. A signature stamp may be used.</p>
86.	DATE BILL SUBMITTED	<p>REQUIRED – Enter the original claim submission date. For resubmissions, be sure to indicate the original submission date, not the date of resubmission.</p>
BACK OF FORM	NOTE	<p>REQUIRED – The back of the claim form must be intact on every claim form submitted.</p>

Reserve page 35 for Claim Form, UB-92, HCFA-1450.

Reserve page 36 for Claim Form, UB-92, HCFA-1450.

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B. Facsimile of Claim Form, UB-92

(See the preceding pages for a facsimile of the front and back of the claim form.)

II. REMITTANCE ADVICE AND EXPLANATION

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

A. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.


PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made.

SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims, with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

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An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit minus the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.


Regardless of one’s understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Outpatient and Inpatient Remittance Advice

Examples of the *Remittance Advice* and a detailed field-by-field description of each informational line for both inpatient care follows. It is important to study this example to gain a thorough understanding of each element, as each *Remittance Advice* contains important information about claims and expected reimbursement.

Reserve page 39 for Remittance Advice.

Page 40 was intentionally left blank.


 Iowa Department of Human Services	CHAPTER SUBJECT: BILLING AND PAYMENT SKILLED NURSING FACILITY	CHAPTER PAGE
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C. Inpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* number.
3. Date claim paid.
4. Billing provider's Medicaid (Title XIX) number.
5. *Remittance Advice* page number.
6. Type of claim used to bill Medicaid.
7. Status of following claims:
 - ◆ **Paid** – claims for which reimbursement is being made.
 - ◆ **Denied** – claims for which no reimbursement is being made.
 - ◆ **Suspended** – claims in process. These claims have not yet been paid or denied.
8. Recipient's last and first name.
9. Recipient's Medicaid (Title XIX) number.
10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Coverage dates as they appear on the claim.
12. DRG code.
13. Total number of covered days.
14. Total charges submitted by provider.
15. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.



16. Total amount of Medicaid reimbursement as allowed for this claim.
17. Total noncovered charges as they appear on claim.
18. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.
19. Medical record number as assigned by provider; 10 characters are printable.
20. Difference between submitted charge and reimbursement amount.
21. Adjusted claims and reason codes. Codes are explained at the end of the *Remittance Advice*.
22. Difference in submitted charge and reimbursement amount resulting in a credit to Medicaid.
23. Remittance totals (found at the end of the *Remittance Advice*):
 - ◆ Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
 - ◆ Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
 - ◆ Number of denied original claims and amount billed by provider.
 - ◆ Number of denied adjusted claims and amount billed by provider.
 - ◆ Number of pended claims (in process) and amount billed by provider.
 - ◆ Amount of check.
24. Description of individual adjustment reason codes.
25. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

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III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

Consultec, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422


To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Send this form to:

Consultec, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

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A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program
PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ☐ Claim copy ☐ Remittance copy
☐ Other pertinent information for possible claim reprocessing.

I N Q U I R Y A	1. 17-DIGIT TCN	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	
	2. NATURE OF INQUIRY		
	(Please do not write below this line)		
	FOR CONSULTEC RESPONSE		
I N Q U I R Y B	1. 17-DIGIT TCN	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	
	2. NATURE OF INQUIRY		
	(Please do not write below this line)		
	FOR CONSULTEC RESPONSE		
Provider Signature/Date:		MAIL TO: CONSULTEC P. O. BOX 14422 DES MOINES IA 50306-3422	Consultec Signature/Date:
Provider Please Complete:	7-digit Medicaid Provider ID# _____ Telephone _____		(FOR CONSULTEC USE ONLY) PR Inquiry Log # _____ Received Date Stamp:
Name Street City, St Zip	<div></div>		

Page 46 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.																	
<input type="checkbox"/> CLAIM ADJUSTMENT <ul style="list-style-type: none"> ◆ Attach a complete copy of claim. (If electronic, use next step.) ◆ Attach a copy of the Remittance Advice with corrections in red ink. ◆ Complete Sections B and C. 	<input type="checkbox"/> CLAIM CREDIT <ul style="list-style-type: none"> ◆ Attach a copy of the Remittance Advice. ◆ Complete Sections B and C. 	<input type="checkbox"/> CANCELLATION OF ENTIRE REMITTANCE ADVICE <ul style="list-style-type: none"> ◆ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ◆ Attach the check and Remittance Advice. ◆ Skip Section B. Complete Section C. 															
SECTION B:																	
1. 17-digit TCN																	
2. Pay-to Provider #:									4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)								
3. Provider Name and Address:																	
5. Reason for Adjustment or Credit Request:																	
SECTION C:		Provider/Representative Signature:															
		Date:															
CONSULTEC USE ONLY: REMARKS/STATUS																	
Return All Requests To: Consultec PO Box 14422 Des Moines, IA 50306-3422																	

October 18, 1995

For Human Services Use Only

General Letter No. 8-A-AP(II)-569

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

SKILLED NURSING FACILITY MANUAL TRANSMITTAL NO. 95-1

Subject: Skilled Nursing Facility Manual, Chapter E, "Coverage and Limitations," pages 9, 10, and 13, revised.

These revisions implement automated approval for skilled care for skilled facilities and swing bed hospitals and reserve bed days. This eliminates the need for stickers for claims and for letters for prior approval. The Iowa Foundation for Medical Care will begin sending a computer tape to Unisys to be used in processing skilled care claims for dates of service on and after November 1, 1995.

Date Effective

November 1, 1995

Material Superseded

Remove from Chapter E pages 9, 10, and 13, dated July 1, 1994, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

May 28, 1997

For Human Services Use Only

General Letter No. 8-AP-25

Subject: Employees' Manual, Title 8, *Medicaid Appendix*

SKILLED NURSING FACILITY MANUAL TRANSMITTAL NO. 97-1

Subject: *Skilled Nursing Facility Manual*, Table of Contents (pages 4 and 5), revised, and Chapter E, *Coverage and Limitations*, pages 15-17 and 23 through 26, revised, and page 27, new.

These changes remove references to waiver service for respite care, since providers now need to enroll as a waiver provider to provide respite.

These changes update the reimbursement rebasing process for rates effective February 1, 1997.

This also corrects the reference to the prior approval letter for reserve bed days from the Department. The Iowa Foundation for Medical Care issues the approval letter.

Date Effective

February 1, 1997

Material Superseded

Remove from *Skilled Nursing Facility Manual*, and destroy:

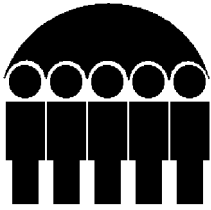
<u>Page</u>	<u>Date</u>
Contents (pages 4 and 5)	July 1, 1994
Chapter E: 15-17, 23-26	July 1, 1994

Additional Information

If any portion of this material is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-113

Employees' Manual, Title 8
Medicaid Appendix

May 21, 1999

SKILLED NURSING FACILITY MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Skilled Nursing Facility Manual*, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, pages 3 through 16 and 19 through 22, revised; Chapter F, *Billing and Payment*, pages 1 through 41, revised; and page 42, new.

This revision:

- ◆ Updates the title of the medical necessity criteria, "Resident Assessment and Services Evaluation."
- ◆ Adds the address for prior approval of out-of-state placements.
- ◆ Revises the process for requesting reserve bed days from the Iowa Foundation for Medical Care (IFMC).
- ◆ Updates form number for the case activity report. These reports are used for communication to the Department by the skilled facility (free-standing, hospital-based, and swing-bed).
- ◆ Revises two of the procedures utilized by IFMC for indicating a need for skilled care.
- ◆ Updates billing and payment instructions in Chapter F.

Date Effective

Upon receipt

Material Superseded

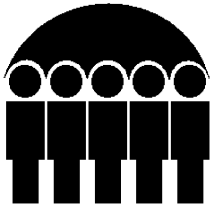
Remove the following pages from *Skilled Nursing Facility Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 5)	February 1, 1997
Chapter E	
3, 4	7/94
5-8	7/91
9, 10	November 1, 1995
11, 12	July 1, 1994
13	November 1, 1995

14	July 1, 1994
15, 16	February 1, 1997
19, 20	July 1, 1994
21, 22	12/92
Chapter F	
1-41	April 1, 1994

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-130

Employees' Manual, Title 8
Medicaid Appendix

January 21, 2000

SKILLED NURSING FACILITY MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Skilled Nursing Facility Manual*, Chapter E, *Coverage and Limitations*, page 17, revised; Chapter F, *Billing and Payment*, pages 6 and 11, revised.

This revision:

- ◆ Clarifies the policy for coverage of orthotic and prosthetic services for persons requiring skilled care.
- ◆ Revises the billing condition code indicating no prior qualifying Medicare stay. This code should be XG instead of X6.
- ◆ Adds revenue code 189 under subcategory 18X for billing for holding a bed while a patient is temporarily away from the facility for visits.

Date Effective

Upon receipt.

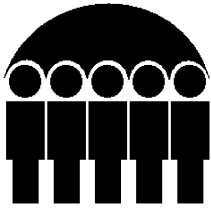
Material Superseded

Remove the following pages from *Skilled Nursing Facility Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Chapter E	
17	February 1, 1997
Chapter F	
6, 11	May 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-148

Employees' Manual, Title 8

Medicaid Appendix

July 12, 2000

SKILLED NURSING FACILITY MANUAL TRANSMITTAL NO. 00-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: **SKILLED NURSING FACILITY MANUAL**, Table of Contents (page 5), revised; Chapter E, *Coverage and Limitations*, pages 21 through 24, revised; and Chapter F, *Billing and Payment*, pages 10, 11, and 31, revised, and pages 43 through 47, new.

This revision:

- ◆ Updates the reimbursement rebasing process for rates effective February 1, 2000.
- ◆ Modifies the billing for ventilator care and increases the incentive factor.
- ◆ Establishes a transitional semi-annual case-mix factor. A semi-annual case-mix factor will be added to the facility's payment rate for those facilities which exceed the Iowa nursing facility case-mix average.
- ◆ Updates the form number for the *Case Activity Report*. This form is now available from Iowa Prison Industries at Anamosa under the number 470-0042.
- ◆ Adds forms 470-3744, *Provider Inquiry*, and 470-0040, *Credit/Adjustment Request*, to Chapter F for provider convenience.

Date Effective

Rebasing was effective February 1, 2000.

All other changes are effective July 1, 2000.

Material Superseded

Remove the following pages from **SKILLED NURSING FACILITY MANUAL** and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents	
5	May 1, 1999
Chapter E	
21, 22	6/97
23, 24	February 1, 1997

Chapter F

10	May 1, 1999
11	January 1, 2000
31	May 1, 1999

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.